Declaration of Tax Status
Alaska Benefit Plans

ALASKACARE Health Plans

FOR OFFICE USE ONLY

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The State of Alaska offers coverage for same-sex partners and their dependent children. In order to ensure proper tax treatment of the benefits for these dependents, the State must know the federal tax status of each dependent enrolled. The tax status of the dependents does not affect their eligibility for coverage but does impact the tax treatment of that coverage. The attached flowcharts are provided to assist you in determining and verifying the federal tax status of your same-sex partner and dependent children. The charts are provided as an overview of the tax rules but given the complexity, we recommend you consult a tax advisor regarding your specific circumstances. Additional information regarding the tax implications is provided on the Same-Sex Partner Affidavit.

List every dependent you are enrolling for health coverage on your dependent enrollment form in this packet and indicate whether they are a federal tax dependent.

Member Name		Member RIN
Health Dependent Name	**Relationship to Member**	**Federal Tax Status**
	Same-sex partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Child of same-sex partner	❑ This person is my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Child of same-sex partner	❑ This person is my tax dependent for purposes of this health plan. ❑ This person is not my tax dependent for purposes of this health plan.
	Child of same-sex partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person is not my tax dependent for purposes of this health plan.
	Child of same-sex partner	❑ This person is my tax dependent for purposes of this health plan. ❑ This person is not my tax dependent for purposes of this health plan.

I understand that my employer has a legitimate need to know the federal income tax status of my relationship with my same-sex partner and their child/children. I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that if any information I have provided is false or misleading, it could result in disciplinary action up to and included termination of employment or ineligibility under the health plan. I agree to notify the Division if there is any change in these circumstances within 30 days of the change. I am aware that changes may impact the tax treatment of my coverage.

Member Signature _____ Date _____

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Answer the following questions for each person you listed on the other side of this form: